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Abstract

Over the past three decades, policy reforms have been geared towards improving quality of care, responsiveness, and equitable access to healthcare services for all social groups in general, and individuals living in marginalizing circumstances in particular. The purpose of this study was to document *how* primary healthcare services (PHC) services are provided in Norway and British Columbia to meet the needs of Indigenous peoples and use this knowledge to critically explore policy alternatives that inform the delivery of PHC for vulnerable populations. Findings show that in British Columbia, Indigenous-specific PHC services have been the preferred mechanism to ensure better care. This is not the case in Norway, where Sámi-centric services exist only in mental health and only in Finnmark.

Keywords

primary healthcare, Indigenous, First Nations, Sámi, policy, international, comparison

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Policy and Practice Options for Equitable Access to Primary Healthcare for Indigenous Peoples in British Columbia and Norway

Internationally, primary healthcare (PHC)¹ renewal continues to be identified as a key pathway to achieving health equity, meeting the needs of underserved and poorly served populations, and for improving the efficiency of healthcare systems (World Health Organisation, 2008; World Health Organisation Commission on Social Determinants of Health, 2008). Evidence shows that when PHC services are not accessible (geographically, economically, or culturally), responsive or effective, people delay seeking help, rely on emergency care, and lose the benefits of continuity of care (Browne et al., 2012; World Health Organisation, 2008). In many countries, histories of colonialism have resulted in power differentials that negatively impact PHC access and responsiveness to Indigenous peoples' needs. Many countries have implemented equity-oriented PHC reforms, balancing universal schemes with targeted interventions (clinics specializing in HIV care or peer-led outreach programs; for example see Benach, Malmusi, Yasui, & Martinez, 2013; Graham, 2004; Lavoie, Boulton, & Dwyer, 2010). Still, finding the right balance between these options is complex and linked to national priorities, history, values, and sensitivities.

The purpose of this study was to document how British Columbia (BC, Canada) and Norway have configured PHC services to meet the needs of: (a) asylum seekers and refugees; (b) drug users; and (c) Indigenous peoples. The specific objectives of the study were: (a) to examine the policy contexts that inform the organization of PHC services for vulnerable and marginalized populations; (b) to identify the approaches used in delivering PHC services to address these needs; and (c) to document the robustness and vulnerabilities of approaches in place for these different populations. Although this article draws examples from services for vulnerable and marginalized populations, the main focus is on services provided to Indigenous peoples.

This article is organized in six broad sections. The next section explores the structure of the PHC system in Norway and BC, which serves as a backdrop to the findings. Section three provides an overview of the theoretical framework informing this study. It begins with a discussion of social constructionist theory in relation to concepts such as marginality and vulnerability. It then explores the link that has been made in the literature between health equity, marginality, and vulnerability. Section four explains how the study was conducted and how the findings were generated. Section five summarizes and discusses the significance of the findings from this study, and a last section explores key lessons and proposes some policy recommendations.

Background: Comparing Norway and British Columbia

Although Canada and Norway share some characteristics, the two countries are undoubtedly different enough to make comparisons of limited utility. The focus of this study was thus with one of Canada's multiple healthcare systems: the system that exists in BC. Table 1 shows selected comparative indicators.

¹ Primary healthcare (PHC) services generally include primary care services provided on an out-patient basis, tertiary prevention interventions designed to assist in the management of complications once they manifest themselves, secondary prevention interventions focused on assisting in the management of chronic illness to avoid or delay the development of complications, and primary prevention activities designed to prevent the onset of chronic conditions (Starfield, Shi, & Macinko, 2005). In Norway, these services are often referred to as "basic services."

Table 1. Selected Comparative Indicators

		Canada	BC	Norway
Population 2007	Total population (1,000,000)	33 ^a	4.3 ^a	4.7 ^b
	Population over 65	13.4% ^a	14.3% ^a	14.6% ^b
Population 2006	Population who are Indigenous	3.7% ^a	4.8% ^a	1.2% ^d
Public Spending	GDP spent on healthcare	10.1% ^b	10.6% ^c	8.9% ^b
	Healthcare spending per capita (CND\$)	\$3,895 ^b	\$3,604 ^c	\$4,763 ^b
	Average annual growth rate of real healthcare spending per capita, 1997 - 2007	3.8% ^b	5.3% ^c	2.4% ^b
	Out-of-pocket healthcare spending per capita	\$580 ^b	n/a	\$720 ^b
	Hospital spending per capita	\$1,070 ^b	n/a	\$1,615 ^b

Note. Sources:

^a Statistics Canada, 2008

^b The Commonwealth Fund, 2010

^c Canadian Institute of Health Information, 2012

^d Statistisk Sentralbyrå, 2014²

BC's healthcare system abides by the five principles of the Canada Health Act 1984 (Canada, 2004), which include public administration, comprehensiveness, universality, portability, and accessibility. In practice, the Canada Health Act guarantees access to medically necessary care (general practitioners, specialists, and hospitals) at no out-of-pocket cost for the patient. As shown in Table 2, BC's five regional health authorities (RHAs) manage and deliver PHC and hospital services for a regionally defined population. Budgets, policies, and priorities are set at the provincial level. Municipalities have no responsibility over health services, except for 169 BC First Nation reserves, which operate like municipalities and deliver a limited complement of PHC services funded by the federal government. Canada's commitment to a multinational state has fuelled discourses on the need for services to be responsive to all and culturally appropriate to minorities (Romanow, 2002). As a result, many provinces, including BC, have adopted targeted strategies to ensure responsive care for all cultural minorities, including Indigenous peoples.

The Norwegian healthcare system is built on the principle of equal access to services: All inhabitants should have the same opportunities to access health services, regardless of social or economic status and geographic location (Johnsen, 2006). Although national policies may acknowledge the need for targeted strategies in the pursuit of equity, Norway has favoured general welfare policies aimed at the entire population and focused on inequalities existing along a socio-economic gradient (Dahl & Lie, 2009; Norwegian Directorate for Health and Social Affairs, 2005; Povlsen, Borup, & Fosse, 2011).

² Statistics on the Sámi population were obtained from the Statistiks Sentralbyrå website (<http://www.ssb.no/>). Because there is no overall registration of the Sámi population, no one knows exactly how many Sámi there are today.

Table 2. Organization of Health Services

	BC	Norway
Regional Health Authorities	• Manage primary, secondary, and tertiary care off-reserve	• Manage secondary and tertiary care
Municipality	• Manage primary healthcare on-reserve (First Nations)	• Manage primary healthcare and, lately, some specialist care
General practitioners	• Paid centrally (provincial), 76% fee-for-service	• Paid centrally, 81% on fee-for-service/capitation/co-payment
Drugs	• 100% out of pocket • Private insurance • Catastrophic expenditures covered through Pharmacare (means adjusted deductible)	• Out of pocket, reimbursed by the National Insurance Scheme (100% - white prescription list; % for blue prescription list)
Dental care	• Out of pocket	• Out of pocket for those over 20

Note. Sources: Johnsen, 2006; Marchildon, 2005

The healthcare system mirrors the political structure of the country, with responsibilities being shared between the national level, the five health regions, and the municipalities. Policies and budgets are set at the national level. The main responsibility for the provision of healthcare services lies with the five health regions for specialist healthcare and the 431 municipalities for PHC (Johnsen, 2006). Norwegian municipalities have shouldered some responsibility for health services since 1860 (Hubbard, 2006). Since 1982, the municipalities have been responsible for health promotion, PHC, care of the elderly, and care of people with disabilities. Although national directives provide broad guidance, each municipality can decide on local priorities and design strategies to meet them. The non-governmental organization (NGO) sector plays a limited role in the delivery of PHC services. In some ways, the municipalities' role in the planning and delivery of PHC may fill a role usually shouldered by the NGO sector in other countries, since municipalities operate with an elected governance structure and must respond to community needs.

The Norwegian and BC healthcare systems have important similarities. Both provide universal access to hospital, general practitioners, and specialists. Both serve populations that are geographically dispersed and with a sizable rural population.

Indigenous Peoples and the Nation-State

Canada and Norway share a long history of recognizing that Indigenous peoples living within national boundaries have rights that go beyond those of other citizens. The interpretation of these rights in contemporary terms is, however, different. In Norway, the Sámi were first recognized as Indigenous peoples in the Stromstad Treaty of 1751, which defined the Norwegian-Swedish border. An addendum to the Treaty, the Lapp Codicil, recognized, in a legal international treaty, the right of the Sámi to freely cross the border as part of their seasonal migration of reindeer herding (Forrest, 1997). In Canada, Indigenous rights are entrenched in the Royal Proclamation of 1763 (King George, 1763). This document, which was issued to clarify the rights of the French and Indigenous

minorities following the conquest of New France by Britain, states that the Indigenous population is not conquered, that they retain title over their ancestral territory, and that encroachment must be negotiated and settled by Treaty.

The Stromstad Treaty and the Royal Proclamation remain foundational documents. International covenants, particularly the International Labour Organisation Convention 169 in the case of Norway (Canada never ratified this Convention), support a concept of Indigenous rights stemming from the continuous occupation of the land. Indigenous peoples' right to the practice of their culture are guaranteed in the Canadian and Norwegian Constitutions (Canada, 1982; Norge Stortingsforhandl, 1986).

Canada and Norway once undertook vigorous programs (*fornorskning* [Norwegianization] in Norway, assimilation in Canada) aiming to assimilate Indigenous peoples into mainstream society. In Norway, the Norwegianization policy resulted in Sámi being forced to forego their own family name and adopt Norwegian names instead, as well as the suppression of language, cultural, and religious practices. This policy was discontinued in 1980 (Jernsletten, 1986; Minde, 2005). Although similar practices were reported in Canada, the negative impact of residential schools has received the most attention. The last of these schools closed in the late 1990s (Robertson, 2006). While overt initiatives have subsided, reports of racism and discrimination remain in both countries (Browne, Fiske, & Thomas, 2000; Hansen, Melhus, & Lund, 2010; Hansen, Melhus, Hogmo, & Lund, 2008; Smye & Browne, 2002). In Canada, and in other countries, the concept of Indigenous rights has been invoked in relation to Indigenous control over PHC services serving their communities (Lavoie et al., 2010). This option has not been pursued in Norway (Baer, 2000; Nynnti, 2000).

In Canada, arguments in favour of Indigenous control over health services have found justification in documented health inequities (Lavoie et al., 2010) and an associated health services' failure to meet the needs of Indigenous peoples. Health inequities have been documented for Indigenous Canadians, whether they are First Nations, Métis, or Inuit (Adelson, 2005; British Columbia Provincial Health Officer, 2009; Martens et al., 2010). Canadian researchers, in partnership with Indigenous groups, have developed methodologies to identify Indigenous peoples (First Nations, Métis) in health administrative data in order to ensure that health inequalities are documented and that evidence-based solutions are in place (Lavoie et al., 2010; Martens et al., 2002; 2010; Martens, Sanderson, & Jebamani, 2005).

In contrast, Norway is not collecting ethnicity information in relation to service provision. This is illegal. Researchers have explored alternative methodologies to document health inequalities among Sámi with mixed results. The methods used for Sámi identification have been based on geography (Gaski, Melhus, Deraas, & Forde, 2011; Norum et al., 2007; Norum, Bjerke, Nybrodahl, & Olsen, 2012; Norum, Hofvind, Nieder, Schnell, & Broderstad, 2012; Norum & Nieder, 2012a; 2012b; Norum, Olsen, Smastuen, Nieder, & Broderstad, 2011). The communities these studies used as proxies for Sámi (including the statistics presented in Table 3) include from 20.3 to 68.4 percent of their population registered as Sámi in the 2005 census (Gaski, 2011). In contrast, the SÁMINOR survey used a mix of geography (the same communities) and self-identification (Broderstad, Melhus, Brustad, & Lund, 2011; Hansen et al., 2008; Lund et al., 2007). This method likely yields more rigorous results, although it has been suggested that self-identification may be hindered by past experiences and distrust. Further, these results cannot be said to reflect the experience of all Norwegian Sámi since the sample includes communities located in Finnmark only (Norway's most northern county).

Table 3. Selected Indicators of Health Inequality

	Canada ^a			Norway ^b	
	National	BC	Indigenous	National	Sámi
Life expectancy, male	78.5	79.2	73	79	77
Life expectancy, female	83.1	83.6	78	83.5	81.6

Note. Life expectancy in years.

^a British Columbia Provincial Health Officer, 2009

^b Because Sámi identification in health service utilization is illegal, the numbers presented are for STN geographical areas, which are the area of activity of the Sámi Parliament subsidy schemes for business development. These areas also include large non-Sámi populations. Caution should be used in interpretation.

Sámi have reported ethnic discrimination. Inequalities in self-reported health have also been documented, compared to the Norwegian majority population (Hansen et al., 2008; Hansen et al., 2010). A dominant discourse is that Sámi's assertion of Indigenous rights is perceived as a demand for special treatment and unfair advantages: This is portrayed as "unequal" and fuels national resentment. This argument can, however, be flipped since the policy of Norwegianization was also fuelled by anti-Sámi sentiments.

In Canada, Indigenous groups have developed determinants of health frameworks to help explain cultural perspectives. Medicine Wheel-inspired frameworks (Assembly of First Nations, 2006) have been developed by Indigenous communities and used to articulate differences in social determinants of health reflecting Indigenous values. The use of the Medicine Wheel, which is a spiritual symbol originating from Cree and Ojibway cultures, has been problematized when applied to all Canadian Indigenous cultures. Further, some traditional elders have expressed distress at the secular use of a spiritual symbol. Despite these reservations, Medicine Wheel-inspired theoretical, analytical, and programmatic frameworks are widely used in Canada, and justified as being more culturally appropriate (Clarke & Holtslander, 2010; Warne, 2005; similar frameworks have been used in other disciplines). The equivalent does not exist for Sámi.

Theoretical Framework

Defining Vulnerability, Marginality, and Underserved Populations in Policy

This study focuses on populations identified (and not identified) in policy as underserved as a result of vulnerability and marginality. In this study, the terms *vulnerable* and *marginalized* are understood as being socially constructed (Schneider & Sidney, 2009), and nation, culture, and context-specific. Populations and individuals defined as *underserved*, *vulnerable*, or *marginalized* in policies are legitimized and elevated to a status of deserving of additional social support, as defined in policy. In contrast, policy silences construct other groups and individuals as not deserving of additional social support (Schneider & Sidney, 2009). Legitimacy is fluid and changing over time. Policy silences are problematic since they effectively transfer the responsibility of providing responsive care to the providers without guidance.

The language of policies speaks of target populations as if these exist with verifiable (although often contested) objective boundaries. Schneider and Ingram (1993) stated that social construction requires that target populations be understood as having shared characteristics that are socially meaningful and that distinguish them from other populations and of the attribution of specific

valence-oriented values (statistics) and symbols (represented in graphs) that reify the construct (Schneider & Sidney, 2009). The construction, they argue, can be positive or negative.

Options for Equitable PHC Delivery

In their landmark book *Accessing Healthcare, Responding to Diversity*, Healy and McKee (2003) propose the following summary of options implemented in higher income countries (Table 4) to ensure responsiveness. There is an obvious gradient in Table 4 in that services identified as alternative or parallel are generally PHC services delivered by non-government organizations that may be entirely funded by governmental authorities and tasked to deliver specific programs (Lavoie et al., 2010). These options emerge generally as a result of failure of mainstream and integrationist strategies to meet the needs of specific populations, and in Indigenous contexts, as an expression of self-determination (Lavoie et al., 2010). Research has documented contractual agreements that narrowly define the population to be served, while providing limited funding to meet stated contractual obligations (Dwyer, O'Donnell, Lavoie, Marlina, & Sullivan, 2009; Lavoie, Forget, & O'Neil, 2007).

Table 4. Service Delivery Models and Population Group Examples

Service delivery models		Definition
Universal	Mainstream (collective)	Health services are made collectively available to everyone, with minority groups expected to use the same health services as everyone else and, arguably, to conform to the dominant conventions.
	Integrationist	Includes a range of activities designed to encourage disadvantaged groups to use collective health services, such as referral services, interpreters, and liaison workers, as well as broader policies to direct resources to those who are disadvantaged.
Targeted	Alternative	Services that exist in addition to mainstream services, with individuals able to choose between the two. Such services are usually limited in scope and scale (e.g., primary care only) and can be of good quality and designed to meet the needs of particular groups.
	Parallel services	Good quality health care system that exists to cater for certain groups and that substitutes for, rather than complements, mainstream services.

Note. Adapted from Healy and McKee (2003).

While mainstream and integrationist strategies are universal strategies that may be better positioned to ensure that services are not delivered *on the cheap* (Ahmad & Bradby, 2007; Titmuss, 1968), interventions established for the majority and untailored to the needs of specific populations may result in lack of responsiveness and worse outcomes. All options above have advantages and challenges to be managed. Generally, universal schemes supplemented with alternative and/or parallel interventions are likely to produce the best outcomes (Healy & McKee, 2003; World Health Organisation, 2008). No matter what option is preferred, legislation, regulations, and monitoring are required to ensure that services are provided in the manner intended, adequately resourced, responsive, and that they result in improving health outcomes.

Methods

The Norwegian component of this mix method study included policy and document analysis; discussions with scholars; and interviews with policy-makers, service providers, and representatives from populations considered vulnerable, Indigenous, and those with documented inequalities. It was funded by the Research Council of Norway and hosted by the University of Tromsø's Department of Clinical Medicine. The BC component was based on published literatures.

In Norway, potential ethical issues were discussed with the Regionale Komiteer for Medisinsk og Helsefaglig Forskningsetikk (REK), the Regional Committees for Medical and Health Research Ethics (n.d.). The study protocol was submitted to REK for review. The REK's response stated that because this project did not require access to personal health information (i.e., medical charts), the collection of biological samples, or a clinical trial, it did not require ethical review by REK. The University of Northern British Columbia's Research Ethics Board approved the project's protocol.

Data Gathering and Analysis

The Norwegian data for this study was collected from policy documents and interviews with researchers, health service providers, and healthcare administrators of the healthcare system. A combination of snowball and theoretical sampling was utilized to identify individuals to be interviewed. Potential interviewees ($N = 47$) were contacted using a standard email written in English and in Norwegian. A bilingual information sheet about the study was included in the email.

Overall, 15 interviews were conducted with 19 individuals: 13 were with service providers, 4 with decision-makers, and 2 with representatives of community organizations. Of these, 5 identified as Sámi (identified as [S], as opposed to [N] for other Norwegians). In addition, conversations were conducted with 5 researchers involved in the fields of health inequalities, non-government organizations, and PHC. Interviews were conducted between September and November 2012. All interviews were conducted in English. In two cases, a colleague trusted by the interviewee, Inger Dadsvold, attended to provide support and occasional Sámi-English translation. Interviews were digitally recorded. Interviewing continued until saturation was achieved (Glaser & Strauss, 2009).

Recordings were selectively transcribed. Full transcription was considered redundant, as all interviews were conducted by Lavoie and analyzed right after the interview. Recordings were listened to twice and key themes identified, collated, and synthesized. Third and fourth listening occurred to verify the analysis. Validation was ensured through periodical presentations ($N = 5$) of key findings to Norwegian peer-researchers and health providers, and cross-referencing with existing literature where available. The documents reviewed were selected based on a published and grey literature search, complemented by recommendations by those interviewed.

Two broad limitations must be acknowledged in relation to this study. First, the author is not fluent in Norwegian or Sámi. Although all interviews were conducted in English, it is clear that all interviewed were working in their second (or third) language and that word choice was sometimes an issue. Consequently, direct quotes are not used.

Second, although Norwegian scholars publish widely in English, many key publications exist only in Norwegian. Some policy documents are translated, but generally, they are abridged versions of the original document. Google translate was used to translate key documents. While the translation provided was at best approximate, this provided sufficient information to be further explored in

discussions. Still, the literature reviewed is likely incomplete since some key references may have been overlooked.

Results

Defining Marginality and Vulnerability in BC and Norwegian Policies

Despite Canada's commitment to PHC and principles of social justice, health inequity remains a pressing national concern. In BC, the Provincial Health Services Authority recently released a discussion paper entitled, *Towards Reducing Health Inequities* (Woermke, 2011), identifying five priority populations: (i) children and families living poverty, (ii) people with mental health and substance use issues, (iii) Aboriginal peoples, (iv) immigrants, and (v) refugees. The discussion paper proposes a number of strategies including the development of health equity target plans, improving health literacy, increasing equitable access to care and expanding population-focused health services, developing intersectoral collaboration, and increasing the capacity of the healthcare system to better serve a culturally and linguistically diverse population. Ensuring the existence of culturally competent policies, programs, and services is recommended.

The language adopted in BC is somewhat different than the policy language used in the Norwegian context. In 2007, Norway released the Storting National Strategy to reduce social inequalities in health, identifying four priorities: (a) reducing social inequalities that contribute to inequalities in health (income and childhood conditions including education, employment, and working conditions); (b) reducing social inequalities in health-related behaviour and use of the health services; (c) targeted (non-healthcare specific) initiatives to promote social inclusion; and (d) the development of cross-sectorial tools (Torgensen, Giaever, & Stigen, 2007). The strategy includes a provision targeting vulnerable groups:

Many disadvantaged people need more targeted services. *Universal schemes must therefore be supplemented with specially adapted services and measures tailored to the individual.*

User oriented and specially adapted public services are necessary to ensure that everyone, regardless of their background and circumstances, has access to equitable services. The Government will take steps to promote inclusion in the workplace, inclusion at school and *adapted health* and social services. (Torgensen et al., 2007, p. 10, emphasis added)

Unlike BC, vulnerable groups are not identified.

Both Norway and BC identify the need for targeted strategies to ensure responsiveness to groups identified as marginalized or vulnerable. Norway has experimented with fine-tuning services for those living with HIV infection, mental health, or addictions issues. Harm reduction-focused services exist (safer injection clinics, for example). Low threshold clinics (drop-in clinics where co-payments are waived) and after hours points of services provide alternatives [N008, N015, N018], with good results (Johansen, Morken, & Hunskaar, 2012). Specialized services exist to support pregnant women at risk of substance use [N014]. Refugee and asylum seekers receive services from mainstream services. The Norsk Organisasjon for Asylsøkere (Norwegian Organisation for Asylum Seekers) provides support to these mainstream health service providers to ensure that services are meeting the specific needs of asylum seekers. Interviewees reported mixed results, noting that mainstream providers are often reluctant to provide services or ill equipped to meet needs, especially for those who experienced torture [N015, N016, N017].

Similar strategies exist in BC. In addition, population-focused health services are part of an official BC strategy, in relation to specific cultural groups such as Indigenous peoples (Woermke, 2011). This is not the case in Norway where national strategies have been favoured [N001, S003, N004, S005, S009], and where the idea of separate services for Sámi has not been pursued by the Sámi parliament (which provides recommendations to the Norwegian parliament; see Semb, 2012 for a detailed discussion) [S002, S007]. Some interviewees suggested that Norway's discomfort with population-focused strategies, when defined in relation to ethnicity, is based on the belief that separate services are inherently discriminatory and potentially stigmatizing [S002]. Others dismissed the importance of ethnicity, suggesting that all inequalities can be linked to education and employment [N013, N019].

According to interviewees [S003, S005, N013, N019], an assumption imbedded in policies is that equal provision of services, guaranteed in policy, results in equal access. Despite documented discrimination, services are thus believed to be sufficiently responsive. The leading discourse is that since all have access to the same services, inequalities that persist must be related to personal choice in lifestyle.

Health inequalities have been documented mostly in relation to the socio-economic gradient and in relation to employment (Hoffmann et al., 2013; Holland et al., 2011; Huijts, Eikemo, & Skalicka, 2010; van der Wel, Dahl, & Thielen, 2012). As noted earlier, ethnicity data is not collected in connection to health service utilization so documenting health inequalities on the basis of ethnicity is not possible. Consequently, strategies have focused on ensuring access to continuous work because, the argument goes, inequalities are related to social exclusion and employment is the antidote (Dahl & Lie, 2009). Critics of this approach have noted that little is said about the type of work created [N14]. Further, since work can be an antidote, few options are available for those who may not be able to work as result of social exclusion, marginalization, or for health reasons (Dahl, 2002).

Indigenous Health Services

Norway identifies five cultural minorities: Sámi, Roma, Romani, Kvens, and Travelers. In the context of this project, these groups were mentioned as belonging to marginalized groups. Of these, only the Sámi have their own policy citing an obligation for health services to meet the needs of Sámi:

Equivalent provision of health and social services must be available to the whole population. The Government will achieve this for the Sámi population by means of an improved knowledge base for employees of municipal services and through owner control of specialist health services. The Ministry of Health and Care Services will make it clear in the annual letter of instructions to the re-gional (sic) health authorities that the rights and needs of Sámi patients for *adapted services* must be investigated and clarified in planning and studies and in the decision-making phase. The Ministry will also strengthen the guidance provided to municipal and county services. (Norwegian Ministry of Labour and Social Inclusion, 2008, p. 9, emphasis added)

The Sámi policy guarantees equivalent access to services, which is a right guaranteed to all cultural minorities. It appears that “adapted services” has been interpreted to mean that Sámi have the right to services in the Sámi language.

When asked about the space given to Sámi culture in PHC services, interviewees first highlighted the issue of language, suggesting that for Sámi whose fluency in Norwegian is limited, services should be available in Sámi [S002, N006]. While there is literature on Sámi cultural beliefs that suggests that traditional modalities (access to traditional food, laying on of hands, distance healing, and “reading” or prayers) could be integrated into health services (Sexton & Stabbursvik, 2010), there is limited evidence that this has been institutionalized [S002]. One interviewee suggested that this was actively discouraged by policies [S007]. Still, two interviewees suggested that some providers quietly facilitate the use of traditional modalities in hospitals [S003, S007]. Another suggested that the inclusion of healers in mainstream services was imprudent, as it could result in increased regulation and distortion of Sámi healing practices [S003].

As noted earlier, Sámi respondents stated that the Sámi parliament has not advocated for Sámi-centric health services, it instead continues to advocate for all services to be responsive to Sámi [S002]. An exception is *Sámisk nasjonal kompetansesenter* (SANKS, alternative services), which provides low threshold mental health services for Sámi. SANKS is located in Karasjok and Lakselv (Finnmark). It is funded by Helse Nord (the Health Authority) to provide psychological and psychiatric services to Sámi children, individuals and families from Finnmark, and to conduct research. SANKS emerged as a result of Sámi advocacy [S005], as a mechanism to address underutilization of mental health services by Sámi. SANKS has made an effort to hire Sámi service providers (mainly psychologists) to increase cultural safety in service provisions. Although SANKS staff have provided Sámi-centred programs in other regions (Sámi-centred services exist nowhere else), it appears that this is no longer being supported [N006]. And while SANKS was at one time recognized as a national Centre of Excellence, it appears that this designation is being reassessed. Interviewees reported that the organization’s broader role and mandate is being implicitly reframed in a more narrow way by decision-makers [S003, N004, S005, N006, S007]. These findings are summarized in Table 5.

In BC, services for Indigenous peoples who still live in their traditional territory are funded by the federal government (parallel services). In certain urban centres, despite a policy of universal access, Health Authorities are funding NGOs to provide services to Indigenous peoples (alternative services). Both types of services have been challenged with underfunding and policy shifts (Lavoie et al., 2005). Despite these challenges, studies have demonstrated these services’ ability to be more responsive to Indigenous peoples’ needs and to deliver on outcomes (such as improved health status and decreased number of avoidable hospitalization) (Browne et al., 2012; Chongo, Lavoie, Hoffman, & Shubair, 2011; Lavoie et al., 2010).

Conclusions and Implications for Policy

Finding the right balance between universal measures and targeted strategies may be more of an art than a science. Alternative and parallel services can play an important role in meeting unmet needs. Although they run the risk of being welfare on the cheap (Titmuss, 1968), regulation and monitoring can mitigate this risk.

Table 5. Primary Healthcare Services Strategies for Indigenous Peoples

Country	Example	Service Delivery Type		Documented responsiveness	Vulnerability
		Parallel	Alternative		
Canada	PHC services on-reserve (NGOs funded by the federal government). NGOs in larger cities provide PHC or bridge services.	√		Yes (Browne et al., 2012; Lavoie et al., 2010).	Some vulnerability related to funding (Lavoie & Forget, 2008; Lavoie et al., 2007).
Norway	SANSK, mental health in Karasjok and Lakselv.		√	Interviews suggested that responsiveness was mixed, depending on the provider.	Some vulnerability especially related to the integration of Sámi values.

Norway and BC have opted for different strategies in order to meet the needs of vulnerable, marginalized, and underserved populations. In BC, parallel services have in some cases been preferred: for example, First Nations living on-reserve. Underfunding and vulnerability to policy shifts remain an issue (Lavoie et al., 2005). This is also the case for alternative services, which are vulnerable to underfunding and shifts in policy. Still, studies have demonstrated that Indigenous health services are more responsive and able to produce better outcomes (Lavoie et al., 2010). In Norway, universal schemes have been promoted; yet, some integrationists and alternative strategies have also been implemented. Interviewees suggested that SANKS' role (alternative) has been questioned because its focus is Sámi-specific, suggesting political sustainability issues. Assessing effectiveness in producing better outcomes is constrained by a policy that forbids the collection of ethnicity data in relation to health service utilization.

Titmuss' (1968) statement that "services for the poor will result in poor services" (p. 21), which was used by some interviewees as a rationale for defending Norwegian practices, appears erroneous. While targeted services may be underfunded and challenged by policy, some parallel and alternative services have been shown to produce better outcomes than mainstream services. The saying should be revised to state that *in the absence of policy commitments and regulations, services for the poor may be impoverished services (welfare on the cheap) that might nevertheless produce better outcomes for marginalized populations*. The distinction is important.

The dilemma between universal versus targeted strategies is well documented: either option can result in the perpetuation of inequities. Regulation and monitoring are key. BC is more actively engaged in monitoring the performance of its healthcare system in relation to underserved population. Monitoring is however underdeveloped in Norway, and is linked to discomfort related to documenting inequalities for Sámi. Thus, Norwegian claims of more equalitarian outcomes must be treated with suspicion and challenged.

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